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August 10, 2009

BY MESSENGER AND FIRST CLASS MAIL

Leslie E. Johnson
Hearing Officer
Department of Insurance, Securities and Banking
810 First Street NE, Suite 701
Washington, DC 20002

Re: GHMSI Surplus Evaluation – Emergency and Proposed Rulemaking

Dear Ms. Johnson:

D.C. Appleseed appreciates the opportunity to submit the following comments in response to the Notice of Emergency and Proposed Rulemaking, published in the D.C. Register, Vol. 56, No. 28 at 005665-69. We are pleased that the Commissioner is formalizing a process by which to evaluate GHMSI's surplus pursuant to the Medical Insurance Empowerment Amendment Act of 2008 (the "Act"), but we suggest that the proposed rule be revised to achieve three important ends: (1) clarification of the determination to be made as part of the Commissioner's "preliminary analysis;" (2) clarification of the method of allocating GHMSI's surplus; and (3) reiteration of the applicable legal standard for the Commissioner's surplus evaluation—stated in the Act itself—that GHMSI "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency." We believe that these changes will ensure that the public's interest in GHMSI's assets will be sufficiently protected and will make the process of evaluating GHMSI's surplus less vulnerable to a procedural attack. We have attached our proposed revisions both in redline form and as a clean copy.

I. Clarifying the "Preliminary Analysis"

In the surplus review currently underway, the Commissioner's preliminary analysis appropriately addressed the threshold question of whether GHMSI's surplus exceeds the stated risk-based capital requirements set out by the NAIC and the BCBSA.[1] But the language of the proposed rule could also be interpreted to require a more extensive preliminary analysis, which could in turn implicate the DC Administrative Procedures Act (APA) (DC Code § 2-501 et seq.) and

[1] Dept. of Insur. Securities and Banking, *2009 Group Hospitalization and Medical Services Inc. Adequate Surplus Determination*, July 22, 2009.

potentially form the basis of an effort to challenge the Commissioner's determination on due process grounds.

While not conceding that such an effort would be legally appropriate, we nevertheless suggest that the "preliminary analysis" step set forth in the proposed rule be clarified to reflect the inquiry actually made by the Commissioner as part of the current surplus review. Specifically, the rule should explicitly state that the preliminary analysis should consist only of a comparison of GHMSI's surplus and the stated risk-based capital requirements. If the company's surplus exceeds those requirements, the Commissioner would be required to make an initial determination that GHMSI's surplus is excessive and to hold a hearing to further evaluate whether the surplus is also "unreasonably large." We do not believe that this simple calculus—based on publicly available information rather than any complex analysis—will take much time or is likely to result in the applicability of the APA.

A more extensive preliminary analysis, in which the Commissioner could potentially conclude that that the company's surplus is both excessive and unreasonably large could conceivably be construed as an "order" that would require the procedural protections of the APA to apply. We do not believe that these additional procedural steps would serve the process of evaluating GHMSI's surplus. While we think that the invocation of the APA as a result of a preliminary analysis is uncertain, we believe the approach we have described would reduce that likelihood while simultaneously ensuring a fair and transparent process for GHMSI and the public.

II. Clarification of the Allocation Method

We are concerned that the proposed regulation does not include an appropriate definition of the term "allocation."

For the following reasons, we think the appropriate measure of GHMSI's surplus attributable to the District must include the proportion of premiums from all sources related to business that originates in the District—i.e., surplus should be allocated based on the jurisdiction in which the insurance policy was written. For most employer-sponsored group insurance policies, the surplus will therefore be allocated to the jurisdiction where the employer is principally located. For individual policies, the surplus will be allocated to the jurisdiction in which the individual resides. Support for this allocation is as follows:

A. Allocation Based on Location of Employer Is Consistent with Maryland and GHMSI Practice.

1. Maryland Premium Tax Exemption Reports

Maryland imposes a premium tax on all premium revenues "reasonably attributable" to insurance business in the State. Maryland grants a premium tax exemption, however, equal to any amount spent by a nonprofit health service plan in a manner that serves the public interest, including that the funds must be used, at least in part, to subsidize certain specified programs, including the

Senior Prescription Drug Assistance Program, the Maryland Pharmacy Discount Program, and the Community Health Resources Commission.[2]

On October 16, 2008, Maryland Insurance Commissioner Ralph Tyler determined that GHMSI's 2007 Premium Tax Exemption Report complied with Maryland law.[3] As part of that determination, Commissioner Tyler implicitly endorsed GHMSI's method of allocating premium revenue to Maryland, which GHMSI had reported consistently on Schedule T of its Annual Statement.[4] Accordingly, for 2007, GHMSI allocated 64% of its total premiums, including commercial and FEHBP policies, to the District.[5]

The relevant portions of GHMSI's 2007 Schedule T are summarized in the following table:

GHMSI 2007		**Commercial**		
	Total: FEHBP + Commercial	Total	Comprehensive (Major medical)	Medicare and other
DC	$ 1,792,818,853	$ 366,790,524	$ 343,659,577	$ 23,130,947
Maryland	$ 631,314,306	$ 631,314,306	$ 577,557,934	$ 53,756,372
Virginia	$ 384,792,858	$ 384,792,858	$ 367,639,580	$ 17,153,278
DC	64%	27%	27%	25%
Maryland	22%	46%	45%	57%
Virginia	14%	28%	29%	18%

Thus, based on Maryland law and consistent with GHMSI's past practices, the proper allocation method for GHMSI surplus should be based on the jurisdiction in which the insurance policy was written.

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2 Md. Code Ann., Ins. § 6-101(b).

3 *See* Md. Ins. Admin. Order (Oct. 16, 2008), attached as Exhibit 1.

4 Apart from the Schedule T, we were unable to locate any reports or other documents indicating how GHMSI allocates revenue for Virginia. We were not able to find any Virginia law or practice requiring GHMSI to use any particular methodology for allocating revenue. Thus, we are unaware of any basis upon which Virginia might oppose an allocation based on the state in which the contract was written, as is set forth in Schedule T, which is in fact how GHMSI allocates revenue as to all three jurisdictions.

5 GHMSI's allocation for FY2008 appears to be consistent with previous years.

2. Maryland Act HB1534/SB1070

Recent legislative activity in Maryland reinforces this view. Pursuant to Maryland Act HB1534/SB1070, enacted effective June 1, 2009, the Maryland Insurance Commissioner is authorized to review and evaluate the effects of any surplus evaluation conducted by another state but only with respect to "premiums charged to subscribers under policies issued or delivered" in Maryland. Although the Act does not define "issued or delivered" for purposes of allocation, a review of case law suggests that the phrase should be defined according to place of employment.

By way of analogy, some cases discussing choice of law provisions for group life insurance policies rely on the Restatement (Second) of Conflicts of Laws § 192 in defining "policies issued or delivered." The Restatement explains that the rights of an insured should be determined "not by the local law of the state where the employee was domiciled and received his certificate but rather by the law governing the master policy....This will usually be the state where the employer has his principal place of business."[6]

Finally, allocation based on where the policy is written is sensible when considered in view of the Maryland and Virginia Insurance Commissioner's authority to regulate rates under policies issued to private employers. Specifically, it would not appear that the insurance commissioners in either jurisdiction would have the authority to regulate health insurance rates of private employers located in the District and whose policies issue from the District. Similarly, they may not regulate rates under FEHB contracts for federal employees who reside in Maryland or Virginia. It thus seems logical that the allocation method flowing from where a contract is "issued or delivered" should be coterminous with the reach of the rate regulation authority of the insurance commissioners of neighboring jurisdictions with respect to policies issued to private employers.

B. Principles of Fairness and Ease of Administration Support Allocation Based on Place of Employment.

GHMSI is the largest FEHBP insurer in the national capital area, and FEHBP represents the largest share of GHMSI's business. In 2003, FEHBP accounted for 57 percent of GHMSI's earned premiums. As Maryland is not permitted to regulate FEHBP premiums, those revenues will not be evaluated for any purpose if the District does not consider them in the surplus determination, essentially rendering the FEHBP premiums exempt from consideration. Were that to occur, GHMSI could seek to continue to increase its overall surplus based on revenues from FEHBP, the provision of the Act that GHMSI should engage in community health

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[6] *Cf. Guardian Life Ins. Co. of America v. Insurance Comm'r of State of Md.*, 446 A. 2d 1140 (Md. 1982) (holding that a policy delivered to a Rhode Island trustee was not "issued or delivered" in Rhode Island but was instead issued or delivered in Maryland, the state in which the employer was located).

reinvestment "to the maximum feasible extent consistent with financial soundness and efficiency" notwithstanding. In other words, carving out FEHBP from the surplus analysis would undermine the ability of the District to implement effectively this legislation and thus frustrate the very purpose of the legislation to create a framework whereby GHMSI is held to account for any excess surplus it generates. Given that the company's assets are owned by the public and given the express language of the Act, the Commissioner should not permit certain types of premiums to be excluded from his surplus review.

Also, it is necessarily easier to allocate premiums based on where the contract is written because GHMSI has ready access to that information. Information concerning where the contract is written (at least as to employer-sponsored group insurance policies) is more likely to be current and accurate than other available methods, such as residence of subscriber. Thus, it would appear likely that the administrative costs associated with conducting an accurate allocation would be substantially less when allocating premiums based on where the contract is written. As the Act requires an annual analysis of GHMSI's surplus and requires that it be done with reasonable alacrity, easing the administrative costs and reducing the time to conduct the analysis is in the public interest.

III. Inclusion of the Applicable Legal Standard

The Act requires GHMSI to "engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency."[7] We suggest revising the surplus review procedures in the proposed regulation to refer expressly to this governing legal standard.

In the two-step process prescribed in the proposed rule, the Commissioner first determines any amount of surplus that is over the NAIC and BCBS minimums to be "excessive." In the second phase of the review, the Commissioner then determines whether the surplus is "excessive and unreasonably large." The Act does not expressly define the terms "excessive" and "unreasonably large," nor does it use the terms interchangeably. The Commissioner's determination that the surplus is "unreasonably large" may be made only after a hearing in which the Commissioner also finds that the excess surplus is "inconsistent with the corporation's obligation . . . to engage in community health reinvestment to the maximum feasible extent consistent with financial soundness and efficiency."

Including this legal standard in the definition of "unreasonably large surplus" would also distinguish the Commissioner's second, more extensive analysis from the pro forma preliminary analysis of whether the surplus exceeds the NAIC and BCBS standards.

* * *

[7] Medical Insurance Empowerment Act, Sec. 2(c); codified at DC Code § 31-3505.01.

We have also suggested a handful of other changes to the proposed rule (e.g., increasing the page numbers for the report, permitting the Commissioner to expand the time for a party to testify, and otherwise trying to make the document internally consistent), but we view them as more modest in nature.

Sincerely,

Walter Smith